



CHAG NEWS

A Newsletter of the Christian Health Association of Ghana

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Health in Body, Mind and Soul

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Dr. Gilbert Buckle addressing the group

Ghana Health Service (GHS) and Christian Health Association of Ghana (CHAG) sign Memorandum of Understanding (MOU)

The Ghana Health Service and the Christian Health Association of Ghana are the two largest Health Service Delivery Agencies of the Ministry of Health.

Message from the Executive Director

CHAG continues to look for innovative ways of improving health services with limited resources to our clients. However, this does not always translate in improved health outcomes.

The outcomes of some of the key health indicators showed slightly improved trend while others were stagnating. This may be due to mirage of challenges: shortages of critical clinical staff, uneven distribution of available staff across the network, persistent delays in NHIA claim reimbursement etc.

The Secretariat continues to engage the NHIA on the persistent delays in claim reimbursement and the low tariffs being paid for services (general and specialist) and commodities.

CHAG has revised its 2012-2016 Strategic Framework into a 2014-

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They have largely over the years been operating parallel Health pro-programmes towards the overall achievement of the goals of the Health Sector, with little or no institutional framework to guide their operations for the efficient and effective delivery of their mandates.

GHS and CHAG therefore saw the need to collaborate to pool resources together, realign programmes and operations to prevent wastage, leverage cross agency competencies to promote synergy and better health outcomes in the light of dwindling global and national resources.

It is in this light that on Friday, 13th December, 2013 a MoU was signed between these agencies.

The MoU is based on the Health Systems Framework as defined in the Ouagadougou Declaration on Primary Health Care and Health Systems. The partnership relationship is described for all the nine (9) Health System areas

as follows; Leadership & Governance, Human Resource for Health, Health Service Delivery, Health Financing, Health Technologies, Health Information, Community Ownership and Participation, Partnerships for Health Development and Research for Health.

The MoU is expected to be used as a reference document guiding all relationships and interactions between the GHS and CHAG in the organization, delivery and monitoring of health care services. It is hoped that, the spirit of the document 'transparent, effective and efficient partnership in the interest of the people of Ghana' will at all times be kept in mind to guide the relationship between the two organizations.

It is envisaged that an improved relationship will ultimately support the achievement of universal coverage of healthcare services and improve quality of care to all people living in Ghana. ■



DG- GHS and ED - CHAG signing the MOU at the GHS Conference Room

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EDITORIAL

Any organization or entity that fails to embark on periodic introspection is bound for serious institutional challenges and failure. It is for this reason that the leadership and the entire membership of CHAG deserve commendations for embarking on the Systems Thinking (ST) and Health System Strengthening (HSS) initiative.

This comes on the heels of the remarkable success of the Project Five Alive which has come to reduce under-five mortality nationwide.

The success of the ST/HSS concept/initiative in improving outcomes in all areas of study in the pilot facilities are matters of platitude. Reduction in NHIS Claims rejection and maternal mortality, increased OPD attendance culminating in improved revenue among others, are the cardinal reasons why scaling up of the concept/initiative to encompass all CHAG facilities would help improve health care delivery, ensure efficient resources utilization and generate maximum results.

The scaling up of the HSS to all CHAG facilities would not come without teething challenges, but it is imperative for its implementation to be seen as a matter of priority.

To this end facilities should be equipped and encouraged to adopt HSS to help improve quality services delivery within CHAG.

If CHAG member facilities would improve efficiency in the use of resources and continue to grow in a manner that would make the desired impact, then HSS approach is certainly the way to go.

The six pilot facilities and the entire project team definitely deserve commendation for a good job done and pointing the way forward.

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2016 strategic framework. The aim of the current framework is to focus on improving CHAG's contribution to the National Health Sector outcomes. It also provides the framework to support the network members formulate plans that reflect our individual as well as our collective mandates.

CHAG continues to enter into partnerships that support improved health outcomes. CHAG and the GHS have agreed to improve cooperation for better health service delivery through the signing of a Memorandum of Understanding (MOU). The MOU aims at improving collaboration between CHAG Member Institutions (MIs) and the GHS in the Regions, the Districts and the Sub-Districts. ■



Member Institutions in Koforidua to Review Performance and take critical decisions concerning Health Care Provision

PERFORMANCE OF CHAG

CHAG remains visible and relevant in the health sector due to effort of a sustained process of Institutional and Organizational Development of the network coupled with continuous professional education of professional staff categories for improved quality of care.

The information provided here is on the performance, outcome and status of CHAG in 2013. It is structured along the nine (9) systems blocks of Health Systems Strengthening (HSS) model.

1. Leadership and Governance

This relates to providing the direction and the structures directed at ensuring proper stewardship, leadership and managing CHAG health facilities and the CHAG network in the most effective way to achieve the desired outcomes/impact.

During 2013, CHAG finalized a new 3-year strategic framework for the entire network providing direction for all CHAG agencies to prepare work plans for the period 2014-2016.

At the National level, CHAG continued to participate in health sector meetings and technical working groups to promote member's interest, influence health sector policy and advance the health sector (e.g. Health Summit, Health Business meetings, Ministerial HRH-Committee, NHIA advice committee, Parliamentary Select Committee Health, etc.). CHAG engaged in a strategic partnership with the GHS through the signing of a MOU supporting closer collaboration and improved alignment at the Regions and Districts.

CHAG further developed and tested the network's corporate M&E tool. The M&E tool provides a framework of indicators and measures to assess organizational performance and health outcomes of CHAG health facilities. The tool will be further tested on a larger scale during 2014.

2. Human Resource for Health

The production, distribution, development, retention and utilization of a workforce of the appropriate quantity, quality and skill mix is essential to secure effective and quality health services.

CHAG Calendar of Key Events

Board Meeting: 27th March, 15th April, 31st July, 22nd November
Church Health Coordinators Meeting: 20th March, 19th Sep.
Annual Review Meetings of Church Health Units: As and when

TIT BITS

Membership requirements

Do you know that, in order for Christian health / training facilities to be considered for membership with CHAG, the following criteria must be met?

No.	Criteria For Membership Of CHAG
1.	Be a registered member of either: a. The Christian Council of Ghana b. The Ghana Catholic Bishops Conference c. The Ghana Pentecostal Council; d. Or any CHAG recognised national Christian Church Institution, in so far as it is not based on individual ownership,
2.	Be formally recognised and approved by the Head of respective Church Institution
3.	Be a not-for-profit institution
4.	Be registered with the Health Facilities Regulatory Agency
5.	Be a recognised health care provider by the district and regional health authorities of the Ghana Health Services
6.	Fulfil the defined quality standards for service provision and training
7.	Be willing and committed to further strengthen partnership with the MOH and its agencies in accordance with the MOU between the MOH and CHAG
8.	Have settled applicable admission fees

The total number of staff employed in CHAG health facilities in 2013 was 11,127; an increase of 1771 (18.9%) compared to 2012. About 60% of all staff are working with the National Catholic Health Service (NCHS), 13% with the Presbyterian Health Service (PHS), 10% with the Seventh-Day Adventists (SDA), 4% with the Methodist Health Service and 4% with the Pentecost Health Service. The remaining staff (9%) are employed by the remaining 16 church denominations under CHAG.

CHAG continued to provide facilitative, financial and capacity training support in the area of HR management and planning to a significant number of MIs. CHAG has adopted the Work Indicator for Staffing Needs (WISN) for use across the network. About 60% of CHAG facilities have been trained in the use of this application. Furthermore, capacity support to CHAG members continued in the area of organizational development and training in health systems strengthening (HSS), community systems strengthening (CSS), advocacy and policy influencing (API) and organizational performance management (OPM). The HR unit of the secretariat was expanded with 4 additional staff.

3. Health Service Delivery

CHAG continues to provide primary, secondary and tertiary health care services as well as preventive, promotive and rehabilitative services to its clients in hard-to-reach and deprived areas of the

country. The services are provided in line with national priorities and standard treatment guidelines and protocols.

CHAG received funding from DFID to improve mental health over a period of 5 years. The overall aim of the programme is to improve the quality of life of persons suffering from mental illness.

Health Outputs

The increasing volume of OPD clients since 2010 is slowly stabilizing during 2013 with just a slight increase of 1.3% compared to 2012 (Table 1). Over 95% of OPD clients are insured with the National Health Insurance Scheme (NHIS).

The table below shows the overall outcome performance of CHAG on selected key health indices.

Table 1: Selected Key Health Indicators

Health Indicator	2010	2011	2012	2013	4-Year Trend
Maternal Mortality	181	254	187	177	Improving
Infant Mortality	12.4	12.9	5.9	7.9	Fluctuating
Under-5 Mortality	11.2	9.2	6.5	7.7	Fluctuating
Still Births	3.7	2.9	2.5	2.3	Improving
Crude Mortality Rate	39.7	25.7	22.4	23.1	Fluctuating

4. Health Financing

Financing of CHAG was mainly through the GOG (Salaries and Personnel Compensation), Non-Tax Revenues (IGF)

and Donor support, mostly through project grants. IGF, remained the largest source of income with 65% of total income, followed by GOG and Donor support of 34% and 1% respectively. About 85% of IGF was generated through claim payments by NHIA whereas about 15% was generated through direct payments by clients for services rendered.

NHIA claim management and administration further improved across the network. An electronic claim pilot in collaboration with the NHIA continued in 11 CHAG institutions. However, persistent delays in NHIA claim reimbursement remained a serious concern with an average delay of 4-6 months resulting in serious liquidity problems in many CHAG health facilities. In addition, tariffs for medicine were considered to be too low and not in line with inflation rate. Tariffs for specialized medical services at secondary and tertiary hospital level remained low. This is issue of great concern for the network.

The majority of CHAG members were financially solvent although some continued to require financial support from their parent churches in the areas of staff salaries and capital expenses. Overall, CHAG hospitals improved their financial and revenue administration and management.

5. Health Technology

A large majority of CHAG facilities is owned by the Catholic Church (43%) followed by the Presbyterian Church (16.5%) and the Seventh Day Adventist Church (9%). The Salvation Army, Anglican Church, the Methodist and the Church of Pentecost each own about 4.5% of facilities. The remaining 14 other

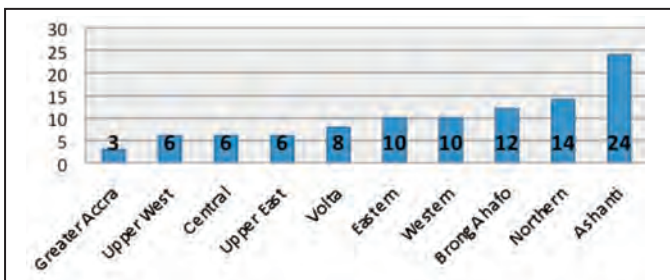
Church denominations each own less than 1% of CHAG facilities. In all, the network accounts for approximately 5.3% of the total health

infrastructure in Ghana. CHAG health facilities are unevenly distributed in the ten regions of the country and particularly located in isolated districts and areas (Graph 1).

for health records, school management and student records continued to be piloted in 3 health institutions and 1 training school.

rested in operational research which looks into causes of common or critical problems in the implementation of health services in the health facility. The purpose of operational research is to promote contextual solutions and improve the quality and effectiveness of health services management and care.

Graph 1: Distribution of CHAG Facilities by Region (%)



Of the 183 facilities, a majority is made up by clinics (42%) and hospitals (32%). The remaining facilities are made up by health centres (10%), PHC centres (8%), Training institutions (5%), specialist clinics (2%) and polyclinics (1%) (Graph 1).

Maintenance and renovation of buildings remains a concern with limited funds available, limited support from GOG/MOH and a common lack of maintenance culture.

Overall, shortages in essential medicines and consumables are limited and if at all, they occurred as a result of liquidity problems of the health facility mostly due to late reimbursement of NHIS claims.

6. Health Information

Being an agency of the MOH, CHAG health facilities provide routine health-service data within the Government DHMIS-II system as well as to CHAG Secretariat. CHAG health facilities submitted routine health-service data bi-annually to CHAG for performance reporting. Submission rate of this routine data for 2013 was 90%, a 6% improvement compared to 2012. Overall, CHAG hospitals report close to 100% however about 50% report too late! Reporting of smaller CHAG health facilities remains a challenge over the years and can be improved (Table 2).

Table 2: CHAG Members Reporting (%): 2010 - 2013				
Facility	2010	2011	2012	2013
Hospitals	81%	97%	90%	97%
All Others	80%	69%	81%	87%
Overall	80%	78%	84%	90%

To improve data management across the network, customized ICT software

7. Community Ownership and

Participation Community participation aims at improving acceptability of health services by the community and strengthening behaviors that promote and preserve health.

Following recommendations of the 45th ACCM (2012) a conceptual framework was developed to assist health facilities to purposefully engage with the communities they serve. By engaging with the community, the health facility is able to improve relevance of its services. Moreover, it is proved that involvement and responsiveness of communities in service provision increases health seeking behavior.

8. Partnerships for Health

CHAG continued to actively engage with many stakeholders in the health sector and contributed to National health sector committees, reviews, workshops and technical fora shaping strategies, policies, bills and health sector plans. Whereas traditional donor support to CHAG health facilities is reducing, some partnerships with local and international donors and agencies were initiated across the network in support of specific projects.

At the national level, CHAG maintained strategic partnerships with DANIDA, Cordaid and UNFPA. CHAG has also started to implement a primary mental health care programme with support from DFID.

9. Research for Health

Health research relates to the generation and application of information, evidence and knowledge to improve health systems, health management and health service delivery. CHAG is particularly inte-

rested in operational research which looks into causes of common or critical problems in the implementation of health services in the health facility. The purpose of operational research is to promote contextual solutions and improve the quality and effectiveness of health services management and care.

RESEARCH CHAG Costing Study Objectives

- To determine total and unit cost of services for OPD/IPD/specialist services for all levels of care within the CHAG network.
- To link actual expenditure of hospitals with outputs of each service departments to produce unit cost per departmental outputs
- To gain an understanding of the "building blocks" or components of cost of providing services within CHAG facilities.

Results

Objectives 1 & 2:

CHAG health facilities can estimate both cash and non-cash expenses among final cost centers and be in a better position to negotiate for good prices. Salaries and allowances paid through Internally Generated Fund now forms a major cost component of all the health facilities studied. Administrative costs also constitute an important part of hospital costs and must be noted in efforts to recover costs. National Health Insurance Tariffs for the OPD category of services with the exception of Antenatal is very low.

Objective 3:

Total hospital cost can be an exponential function of: a) input prices b) output types and volume and c) other factors assumed to be determinants of fixed costs.

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